

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

14917
203
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County

Kent

City or town

Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Ayres sen

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m.

w.

married

6. (b) Name of husband or wife

Mary S. Ayres

7. Birth date of deceased (mo., day, yr.)

Dec 26 1860

6. (c) If alive, give age 79 years

8. AGE:

Years
85

Months

Days

If less than one day

..... hrs. min.

9. Birthplace

Rock Hall
(Town, county, and state)

10. Usual occupation

waterman

11. Industry or business

oil

MOTHER FATHER

12. Name

George Ayres

13. Birthplace

Rock Hall, Md

14. Maiden name

Sarah Canterbury

15. Birthplace

not known

16. Informant

Geo. W. Ayres

Address

Rock Hall, Md.

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof Nov 8 1946
(month) (day) (year)

Cemetery or crematory

Worley Chapel

Location

Rock Hall, Md.

18. Funeral director

J. Willis Wells

Address

Chester, Md.

19. May 8, 1946

(Date read by registrar)

S. Edward Burgard

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Kent

City or town

Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 5

1946, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June

1945

to May 5

1946

and that I last saw h. e. alive on

May 4

1946

Immediate cause of death

old age, arteriosclerosis

multi-vascular

Due to

chronic bronchitis, hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Albert A. Burgard

M. D. or other

Address

Rock Hall, Md.

Date signed 7/7/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

04918

Reg. Diat. No. 201

1. PLACE OF DEATH:

County..... Kent
City or town..... Lynch and

How long in above place of death?..... 16 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?.....

3. (a) FULL NAME

Mrs Ida Beck

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female W Widow

6. (b) Name of husband or wife

Frederick Copper

7. Birth date of deceased (mo., day, yr.)

Jan 29 1859

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

87 3 13 hrs. min.

9. Birthplace.....

Kent Co.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

nurse

12. Name.....

Robert Beck

13. Birthplace

Lynch and

14. Maiden name.....

Sarah Brown

15. Birthplace

Kent Co and.

16. Informant.....

John Jewell

Address

Lynch and

17. Burial

Date thereof..... May 18 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Still Pond and

Location

Still Pond and

18. Funeral director

B P Galloway

Address

Still Pond and

19. Date rec'd by registrar

May 15 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Lynch and

Street No.....

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 12 1946 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1946 to May 3 1946

and that I last saw her alive on May 6 1946

Immediate cause of death.....

Diseases

DURATION

5 years

Due to.....

Diseases

2 years

Due to.....

Diseases

4 yrs

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

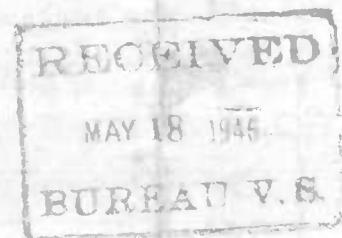
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. daughter

Address..... Date signed..... May 13 1946



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-20

CERTIFICATE OF DEATH

14819
Reg. Dist. No. 200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Kent

City or town Bellington, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

George Gilbert Brown

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

April 27th 46

8. AGE: Years

Months

Days

If less than one day

9. Birthplace Kent Co

(Town, county, and state) Maryland

10. Usual occupation

11. Industry or business

12. Name William E. Brown

13. Birthplace Maryland

14. Maiden name Elsie E. Walls

15. Birthplace Maryland

16. Informant William E. Brown

Address Bellington, Md.

17. Burial Date thereof (month) (day) (year)

Cemetery or crematory Crumpton

Location Crumpton

18. Funeral director E. L. Lane

Address Church Hill

19. May 6 1946 Edward Fellows

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Bellington, Md.

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5th 1946, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 27th 1946, to May 5th 1946,and that I last saw him alive on May 4th 1946.

Immediate cause of death Gas suffocation closure

of heart attack

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Df operations

Df autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

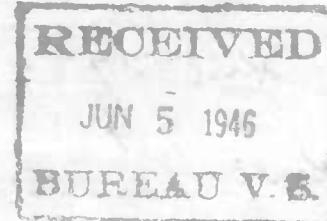
Injured at work?

23. SIGNATURE G. P. Cofield

M. D. or other

Address Bellington, Md.

Date signed May 6th 46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04920

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County

Kent

City or town

Chesterlawn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

left

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Etta B. Chambers

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

fem

col

widowed

6. (b) Name of husband or wife

Isaac Chambers

7. Birth date of deceased (mo., day, yr.)

Dec 15 1880

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Chesterlawn, Md

(Town, county, and state)

10. Usual occupation

house work

11. Industry or business

on home

MOTHER FATHER

George Bratt

13. Birthplace

Hillpond, Md

14. Maiden name

Caroline Starling

15. Birthplace

Chesterlawn, Md

16. Informant

Julia M. Hyndes

Address

103 R.R. Ave Chesterlawn

17. Burial

Date thereof 5-26-1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Timber Creek Cemetery (Col)

Location Chesterlawn, Maryland

18. Funeral director

J. Willis Wells

Address

Chesterlawn, Md

19. May 25 1946

(Date rec'd by registrar)

Clara S. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Kent

City or town

Chesterlawn

(If outside city or town limits, write RURAL and give nearest town)

Street No.

105 Railroad Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 23

1946 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April

1946

to May 23 1946

and that I last saw her alive on

5/22

1946

Immediate cause of death

Pulmonary Tuberculosis
chronic Endo - Myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Alberta Bergard

M. D. or other

Address Rock Hall, Md Date signed 5/23/46

RECEIVED

MAY 28 1946

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

84921

CERTIFICATE OF DEATH

Reg. Dist. No. 201

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Kent
 County: Chester-Town
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, Institution, or street address where death occurred: Kent and Queen Anne's Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Kent
 City or town: C. J. Norton (If outside city or town limits, write RURAL and give nearest town)
 Street No.: Coleman's Corner (If rural, give LOCATION)

3. (a) FULL NAME William Chambers
 4. Sex Male 5. Color or race Black 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Betha Chambers
 7. Birth date of deceased (mo., day, yr.) Unknown 8. (c) If alive, give age years 1878
 8. AGE: Years 68 Months Days If less than one day hrs. min.
 9. Birthplace Kent Co. (Town, county, and state)
 10. Usual occupation Farmer's labor
 11. Industry or business Starkey
 12. Name Wortan Chambers
 13. Birthplace Kent Co. Md.
 14. Maiden name Unknown
 15. Birthplace Kent Co. Md.
 16. Informant Joseph Murphy
 Address 1816 Walnut St. Wilmington
 17. Burial Burial Date thereof May 23/46 (month) (day) (year)
 (Burial, cremation, or removal. Which?) Cemetery or crematory Coleman's, Md.
 Location Near Norton, Md. Rural
 18. Funeral director B. R. Bellows
 Address Still Pond, Md.
 19. May 22 1946 (Date read by registrar) J. M. Clark (Registrar)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1946 at 9:30 P.M.
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 18 1946 to May 19 1946 and that I last saw him alive on May 19 1946

Immediate cause of death: Tuberculous peritonitis DURATION 2 days
 Due to: Inhalation of tubercles of large and small bowel ?

Other conditions: (Include pregnancy within 3 months of death)
 Major findings of operations: Peritonitis, generalized
Intestinal tubercles. Date of op. 5-19-46

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE A. C. Dick M. D. or other Lee S.

Address Chestnutown, Md. Date signed 5-18-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/2

04922

Reg. Dist. No. 202

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Rehoboth

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Sept 15

Hospital, institution, or street address where death occurred:

Rehoboth Am. Freed Hospital

How long in hospital or institution?

13 days

3. (a) FULL NAME

Ida V. Crow

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 23, 1866

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

79

11

21

hrs.

min.

9. Birthplace

Cecil County, Maryland

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

MOTHER FATHER

William J. Crow

MOTHER FATHER

Cecil Co., Md.

14. Maiden name

Anna Maria Rankin

15. Birthplace

Delaware

16. Informant

Hospital Record

Address

Chesapeake, Maryland

17. Burial

Date thereof May 16, 1946

(Burial, cremation, or removal. Whether)

(month) (day) (year)

Cemetery or crematory

Shambly

Location

May Kennedyville

18. Funeral director

Maurine J. William

Address

Chesapeake, Maryland

19. May 15

1946

Clara L. Barnes

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Chesapeake

Street No.

Maryland

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1946 at 1 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to May 13, 1946

and that I last saw h. alive on 19.

Immediate cause of death

Cardiac Nephritis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

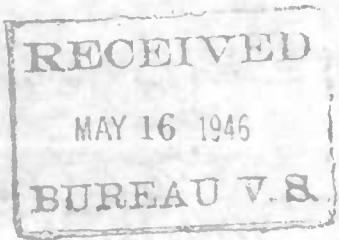
Means of Injury

Injured at work?

23. SIGNATURE

Frank W. Smith, M. D. & other

Address Date signed May 15, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BD*

CERTIFICATE OF DEATH

04923

202

Reg. Dist. No.

1. PLACE OF DEATH: Kent
 County.....
 City or town..... Chestertown
 (If outside city or town limits, write RURAL and give nearest town) life
 How long in above place of death?.....
 Hospital, Institution, or street address where death occurred:.....
 Kent and Queen Anne County Hospital
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Md. County..... Kent
 City or town..... Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... R.F.D.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... No

3. (a) FULL NAME

Mary Emma Goodman

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

female	whit	widowed
--------	------	---------

6.(b) Name of husband or wife..... J. Robert Goodman

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1875
 8. AGE: Years Months Days If less than one day

70	7	27	hrs.	min.
----	---	----	------	------

9. Birthplace..... KENT CO. MARYLAND
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... W.M. F. WOOD MENDER

13. Birthplace..... QUEEN ANNE CO. MD

14. Maiden name..... SARA JANE HOLDEN

15. Birthplace..... QUEEN ANNE MD

16. Informant..... Hospital Record

Address..... Chestertown, Md.

17. Burial..... Date thereof..... May 9, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Chester Cem.

Location..... Chestertown, Md.

18. Funeral director..... J. Willis Wells

Address..... Chestertown, Md.

19. May 9, 1946..... Cleas. Barnes
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number
 none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 6, 1946

I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9, 1946, to May 6, 1946, and that I last saw her alive on May 6, 1946.

Immediate cause of death..... Hyperosidrosis

Due to..... Strains & Dolors

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

local

Date of op.....

Autopsy results.....

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Frank Barnes
 Chestertown, Md. May 9, 1946
 M.D. or other
 Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-6

CERTIFICATE OF DEATH

64924
Reg. Dist. No. 200

1. PLACE OF DEATH:

County Kent County
City or town Mallington, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

non

How long in hospital or institution?

non

3. (a) FULL NAME

maggie Groves

4. Sex

<u>Female</u>	<u>Color or race</u>	<u>5. (a) Single, married, widowed, or divorced</u>
	<u>Colored</u>	<u>married</u>

6. (b) Name of husband or wife

Willie Groves

7. Birth date of deceased (mo., day, yr.)

Dec 9 6 1880

6. (c) If alive, give age years

8. AGE:

<u>66</u>	Years	Months	Days	11 less than one day
			hrs.min.

9. Birthplace

Ind. (Town, county, and state)

10. Usual occupation

House Work.

11. Industry or business

James Jefferson

FATHER
12. Name James Jefferson
13. Birthplace Ind.

MOTHER
14. Maiden name Don't know
15. Birthplace Don't know

16. Informant Joseph Bellows
Address Mallington, Md.

17. Burial Burial Date thereof May 18, 1946
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Hiley Ness Cemetery
Location near Mallington

18. Funeral director Calvin Baker
Address 102 E. Green St. Suite 101

19. Date rec'd by registrar May 13 1946 Edward Bellows
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State M.D. County Kent County
City or town Mallington (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

non

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 13 1946 a.m. 4:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to May 13 1946 and that I last saw her alive on May 10 1946.

Immediate cause of death

Confinement of Mouth DURATION 3pm

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

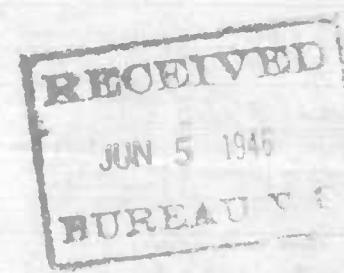
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Mount Zion M. D. or otherAddress Mallington, Md. Date signed 5/13/46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

04925

201

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

35 years

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution?.....

3. (a) FULL NAME

George Washington Jess

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male W Single

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

Oct 22 1872

Years

Months

Days

If less than one day

74

2

13

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Custodian Mail Carrier

11. Industry or business

MOTHER FATHER

12. Name..... Charles W Jess

13. Birthplace.....

Salisbury N.J.

14. Maiden name.....

unmarried

15. Birthplace.....

New Jersey

16. Informant.....

Mrs. G. W. Jess

Address

Betterton Md

17. Burial.....

Date thereof..... May 16, 1946

(month) (day) (year)

Cemetery or crematory.....

Still Pond Md

Location.....

Still Pond Md

18. Funeral director.....

B.M.C. & Sons

Address

Still Pond Md

19. Date record by registrar.....

May 15 1946

(Date record by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County..... Kent

City or town.....

Betterton Md

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 13 1946 at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Wor 5 years 1941 to 5/13/46 1946

and that I last saw him alive on May 13 1946

Immediate cause of death..... Coronary thrombosis, DURATION

Due to..... Valvular insufficiency

Due to.....

Other conditions..... Pneumonia 3 or 4 yrs ago

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

James E. Dedman M.D. M. D. or other

Address..... Box 19 Betterton Md Date signed..... May 14, 1946

RECEIVED

MAY 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23rd

CERTIFICATE OF DEATH

Reg. Dist. No. 200

14926
2.00

1. PLACE OF DEATH:

County

Kensett Chesterville

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

S. S. #

How long in hospital or institution?

3. (a) FULL NAME

Cora S. Johnson

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

James Johnson

7. Birth date of deceased (mo., day, yr.)

March 29 1883

6. (c) If alive, give age years

8. AGE:

Years 63 Months Days If less than one day hrs. min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Samuel Wilson

12. Name

Md.

13. Birthplace

Maggie Turner

14. Maiden name

Md.

15. Birthplace

Agnes Johnson

16. Informant

Rural Chesterville Md.

Address

Burial

Date thereof June 21 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Chesterville

Location

Rural Chesterville Md.

18. Funeral director

Edward Fellows

Address

Millington Md.

19. Date rec'd by registrar

June 1 1946

M. D. or other

Edward Fellows

Registrar

Signature

M. D. or other

Address

Millington Md.

Date signed

6/11/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

Md.

County

Md.

City or town

Rural Chesterville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1946 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 28 1946 to May 28 1946 and that I last saw her alive on May 28 1946

DURATION 6 hours

Immediate cause of death

Hemoptysis

Due to

Otitis Media

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature

M. D. or other

Address

M. D. or other

Date signed 6/11/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7

CERTIFICATE OF DEATH

14927

Reg. Dist. No. 204

1. PLACE OF DEATH:

County..... *Bethesda MD*City or town..... *Bethesda MD*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... *6 hrs*

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?..... *now*

3. (a) FULL NAME

*Frances Rachel Legg*4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*B. (b) Name of husband or wife..... *Violet Lee Legg*7. Birth date of deceased (mo., day, yr.) *July 4 1907*6. (c) If alive, give age *40* years8. AGE: *38* Years *10* Months *27* Days If less than one day *hrs.* *min.*9. Birthplace..... *Bethesda MD*

(Town, county, and state)

10. Usual occupation..... *Housewife*11. Industry or business..... *Housewife*12. Name..... *Helen Elizabeth Legg*13. Birthplace..... *Bethesda MD*14. Maiden name..... *Helen Elizabeth*15. Birthplace..... *Bethesda MD*16. Informant..... *Violet Lee Legg*Address..... *Bethesda MD*17. Burial..... *Burial* Date thereof *May 17 1946*
(Burial, cremation, or removal; Which?) (month) (day) (year)Cemetery or cemetery..... *Chestertown*Location..... *Chestertown, Maryland*18. Funeral director..... *J. Willis Weeks*Address..... *Chestertown, Maryland*19. Date rec'd by registrar..... *May 12 1946* Registrar..... *Frank H. Reed*
(Date rec'd by registrar) (Signature)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *MD*County..... *Bethesda*City or town..... *Bethesda MD*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 11*

19..... 19.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 18 to May 11 1946and that I last saw her alive on *May 11* 1946Immediate cause of death..... *Coronary Atherosclerosis*

DURATION

Due to..... *Age, heart disease*

2 days

Due to.....

2 months

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... *None*Date of op. *no*Autopsy results..... *No*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... *No* Date of.....Where did injury occur?..... *Bethesda* (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work? *No*23. SIGNATURE..... *Frank H. Reed*M. D. or other..... *MD* Date signed..... *May 14 1946*

Address.....

RECEIVED

MAY 20 1946

BUREAU, U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mo. John Barnes
Queen St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-2

14928

CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH:

County KentCity or town Chestertown, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Kent & Queen Anne's Hospital

How long in hospital or institution?

3. (a) FULL NAME

Baby Boy Moore

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MW-

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE: Years X Months X Days X If less than one day
hrs. 30 min.9. Birthplace Chestertown, Kent Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name James William Moore13. Birthplace Centerville, Md.14. Maiden name Catherine Barton15. Birthplace Stevenson, Md.16. Informant Mr. James Lee MooreAddress Centerville, Md.17. Date thereof May 17-46
(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory Stevenson, Md.Location Stevenson, Md.18. Funeral director Barton Bros.Address Centerville, Md.

19. May 16, 1946

(Date received by registrar) Clara S. Barnes
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Queen Anne'sCity or town Centerville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 16 1946 at 12:00 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

May 15 1946 to May 16 1946end that I last saw him alive on May 15 1946

Immediate cause of death

Birth Trauma

Due to

F. O. P. (Premature)Regurgitation

Due to

St. FrancisBirth Trauma

Other conditions

None

DURATION

30 min

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. R. L. Barton Jr. M. D. or other

Address

Date signed 5-1-46

